



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RUSSELL SKINNER MD
2352 WEST NORTHWEST HIGHWAY SUITE 3100
DALLAS TEXAS 75220

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Respondent Name

INDEMNITY INSURANCE CO OF NORTH

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-4855-01

MFDR Date Received

August 19, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As stated in both RFR's and for each respective CPT code that was denied, all correct modifiers were attached to the appropriate CPT codes. The Carrier was provided a copy of the CC Edit/Mutually Exclusive Edit Tables to show that the codes were properly billed..."

Amount in Dispute: \$408.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On 5/17/11, Respondent filed a PLN-1 denying the Claimant's 3/7/11 injury stating that it was exacerbation of his 10/21/09 injury. A copy of this PLN-1 was sent via facsimile to Requestor on 5/19/11. Requestor billed for treatment for the 3/9/11 injury. The treatment was then denied as the injury was not found to be compensable."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 21, 2011 and June 30, 2011	97110 and 97530	\$408.00	\$181.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.203, sets out the fee guidelines for professional medical services provided on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits
 - B15 – Payment adjusted because this procedure/service is not paid separately
 - B13 – Re-evaluated; no additional payment is recommended
 - 245 – Denied per customer request

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307 and are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
2. Did the requestor bill for CPT codes in conflict with NCCI edit?
3. Did the requestor submit documentation to support that the services were rendered as billed?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."
 - Review of the submitted documentation finds that the issue of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute is resolved. Review of the CCH decision signed on November 27, 2011 states in pertinent part, "The evidence presented by the claimant persuasively established a causal connection between the on-the-job accident of March 7, 2011 and the torn lateral meniscus of the left knee..."
 - The disputed charges are therefore eligible for review by Medical Fee Dispute Resolution.
2. 28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
 - NCCI edits were run to identify if the disputed charges contain edit conflicts.
 - The requestor billed CPT codes 97110-GP (2 units) and 97530-GP-59 (2 units) on June 21, 2011 and CPT codes 97110-GP-59 (two units) and 97530-GP-59 (two units) on June 30, 2011.
 - No NCCI edit conflicts were identified. The disputed charges will therefore be reviewed per the applicable guidelines.
3. 28 Texas Administrative Code §133.307 states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division... (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute."
 - The requestor seeks reimbursement for CPT code 97110 rendered on June 21, 2011 and June 30, 2011. CPT code 97110 is defined as "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."
 - The requestor seeks reimbursement for CPT code 97530 rendered on June 21, 2011 and June 30, 2011. CPT code 97530 is defined as "Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes."
 - States in pertinent part, "For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed..."
 - The requestor documented 30 minutes of CPT code 97110 on June 21, 2011 and is therefore entitled to reimbursement for two units.
 - The requestor documented 25 minutes of CPT code 97110 on June 30, 2011 and is therefore entitled to reimbursement for two units.
 - The requestor did not document the time associated with CPT code 97530 rendered on June 21, 2011 and June 30, 2011. Therefore reimbursement is not recommended.

4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."
- Procedure code 97110, service date June 21, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 0.9888 is 0.4446. The practice expense (PE) RVU of 0.38 multiplied by the PE GPCI of 0.995 is 0.3781. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.859 is 0.00859. The sum of 0.81153 is multiplied by the Division conversion factor for \$54.54 for a MAR of \$44.26. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$42.52 at 2 units is \$85.04.
 - The requestor billed two units on June 21, 2011, reimbursement is therefore recommended in the amount of \$90.88.
 - The requestor billed two units on June 30, 2011, reimbursement is therefore recommended in the amount of \$90.88.
 - The requestor is entitled to a total reimbursement amount of \$181.76.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$181.76.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$181.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 12, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.